LONG TERM CAR
LTC FOR

DATE: _____ (PLACE STICKER HERE) AGE:___

ACCOMPANIED BY: ☐ mom ☐ dad ☐ adoptive ☐ foster ☐ care provider ☐ transporter ☐ translator ☐ other____
ALLERGIES: _____
☐ Epi-Pen kit ☐ Medic Alert tag ☐ Latex precautions

Interim History:
_____
_____
_____
_____
_____
_____

Respiratory: ☐ NA
☐ **SVN**:_____ ☐ **O2** @____l/min, ☐*tank* ☐*concentrator*
☐ **Vent**: IMV____, PEEP____, PIP____, CPAP_____ ☐ Pulse Ox. _____
☐ **Trach** (☐Shiley ☐other O.D.____mm, Lt____cm) ☐**Suction** type_____ Cath size_____ Frequency____

Nutrition:
Diet: ☐ regular diet ☐ formula ☐TPN _____
Formula type/amount: _____
Route: ☐ po ☐ npo ☐ng ☐og ☐g-tube ☐g-button (☐Bard ☐Mickey _____Fr, _____cm)
Administration: ☐ Bolus over ____min, q ___hrs ☐ Drip rate: _____
Other: ☐ Fundoplication ☐ Oral aversion _____

Medication	Strength	Amount	Frequency	Comments

Review of Systems: Family History & Social History obtained/reviewed? ☐ no ☐ yes
Lead or TB risk? ☐ yes ☐ no
Menstrual Hx: ☐N/A Menarche_____ yrs, LMP_____ ☐ OCP ☐ Depo-Provera
Implanted Devices: ☐VP shunt (☐ programmable) ☐ Baclofen pump ☐ Nerve stimulator ☐ Insulin pump
Comments: _____

Functional Status	
Mental status	☐ NL ☐ alert ☐ mild DR ☐ moderate DR ☐ severe DR ☐ profound DR
Behavior	☐ cooperative ☐ sociable ☐ hyperactive ☐ aggressive ☐ self-injurious ☐ ritualistic ☐ other:
Impairments	☐ vision (☐ glasses) ☐ hearing (☐ aids) ☐ verbal ☐ non-verbal ☐ sign language ☐ communication device:
Incontinence	☐ N/A ☐ bowel ☐ bladder ☐ CIC catheter type_____ size____ FR, frequency_____ ☐ bowel program:
Hygiene	☐ independent ☐ minimal assist ☐ full assist
Feeding	☐ independent ☐ minimal assist ☐ full assist
Transfer	☐ independent ☐ minimal assist ☐ full assist
Ambulation	☐ independent ☐ minimal assist ☐ full assist
Wheelchair	☐ N/A ☐ independent ☐ minimal assist ☐ full assist
Health team members	
Specialists **C= CRS** **P= Private**	☐ CP clinic ☐ Cardiology ☐ Dietician ☐ Endocrine ☐ ENT ☐ Genetics ☐ GI ☐ Hem/Onc ☐ Neurology ☐ Neurosurg ☐ Ophth ☐ Ortho ☐Psych ☐ Pulmonary ☐ Surgery: ☐ Urology ☐ Specialty team:
Therapies **(S=school, H=home)**	☐ PT: ____ X/wk (__) ☐ OT: ____ X/wk (__) ☐ ST: ____ X/wk (__) ☐ Music ☐ Hippo ☐ Other
School	Name_____ Grade_____ ☐ Integration ☐ Special ed _____ ☐ Type of class:_____ ☐ Modifications➪
Resources	☐ ALTCS ☐ DDD ☐ CRS ☐ Respite ☐ Home health ☐ WIC ☐ Private ins. ☐ Hospice
DME supplier	

(PLACE STICKER HERE)

PHYSICAL EXAMINATION:

Weight	kg	%		**Pulse**	/min		**Pulse-ox**	%
Height	cm	%		**Resp**	/min		**O2**	L/min
FOC	cm	%		**BP**	mmHg			
BMI				**Temp**	°C/F			

General: □active □alert □not distressed □appears non-toxic □ dysmorphic features_____

HEENT: □ WNL □ ABNL_____

CVS: □ WNL □ ABNL_____

Chest: □ WNL □ ABNL_____

Abdomen: □ WNL □ ABNL_____

GU/Anus: □ WNL □ ABNL_____

Musc./Skeletal: □ WNL □ ABNL_____

CNS: □ WNL □ ABNL_____

Skin:_____

ASSESSMENT:

1.

2.

3.

4.

5.

6.

COMPLEXITY: □1 □2 □3 □4 □**S**

Comments:

PLAN:_____
_____

1. **Immunizations:** □**Current** □DTaP □Td □Hib □IPV □HBV □MMR □VAR □HAV □PCV-7 □Influenza □Synagis □Other_____
2. **Medication changes/refills:** □ N/A _____
_____
_____
3. **Lab/ Xray:** _____
4. **Referrals:** □ Dental □ CRS □ Behavioral □ Specialist:_____
□ Other:_____
5. **Equipment:** *Already have*: □ Wheelchair □ Bathchair □ Lift □ Stander □ Car seat □ Orthotic/splint
Need: _□ Wheelchair □ Bathchair □ Lift □ Stander □ Car seat □ Orthotic/splint □
Other_____
6. **Supplies:** *Already have*: □ Monitors □ Formula □ G-tube □ Trach □Oxygen □ Parking sticker
Need: □ Monitors □ Formula □ G-tube □ Trach □Oxygen □ Parking sticker □
Other_____
7. **Forms** related to special needs or involved agency? □**no** □**yes**
(□ Care facility, □ Home Health, □ Special Olympics, □ STP, □ Other_____
)
8. **Multiple issues of care related to primary disability or chronic illness discussed with parent/caregiver**
(□ Guardianship □ Transition □ Health care decisions □ End-of life decisions □
Other:_____)
9. **Clinical Care Coordinator**: _____

Time spent with patient: _____ min.

Return to Clinic: ____ weeks/months Provider: _____ Signature_____ MD